

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Weight in Kilograms:

**PRESCRIBER INFORMATION**

Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

**DRUG INFORMATION**

For initial requests, continue below. For renewal requests, proceed to [Length of Authorization](#). If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

Drug Name/Form:

Strength:

Dosing Frequency:

Length of Therapy:

Quantity per Day:

- FDA indicated medications only

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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1. Is the member is 18 years of age or older? **AND**

Yes     No

2. Is the requesting provider managing the member's obstructive sleep apnea? **AND**

Yes     No

3. Does the member have a diagnosis of moderate to severe obstructive sleep apnea (OSA), defined by an apnea-hypopnea index  $\geq 15$  events/hour and confirmed by polysomnography? **AND**

Yes     No

4. Is the member is currently on or has the member tried, failed, or been unable to tolerate continuous positive airway pressure therapy (CPAP) (an adequate trial is defined as CPAP use for  $\geq 4$  hours per night on  $\geq 70\%$  of nights for two or more months)? **AND**

Yes     No

If unable to tolerate CPAP therapy, please explain the intolerance below:

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5. Does the member have a body mass index (BMI) of  $\geq 30\text{kg/m}^2$ ? **AND**

Yes     No

6. Has the member participated in a weight loss treatment plan (e.g. nutritional counseling, an exercise regimen, and calorie restricted/fat restricted diet) in the past 6 months and will they continue to follow this treatment plan while taking an anti-obesity medication for obstructive sleep apnea? **AND**

Yes     No

7. Does the member does have craniofacial abnormalities that may affect breathing? **AND**

Yes     No

8. Does the member have a diagnosis of central or mixed sleep apnea or Cheyne-Stokes respiration? **AND**

Yes     No

9. Is the member using any other GLP-1 product? **AND**

Yes     No

10. Does the member have pancreatitis, acute suicidal behavior/ideation, or gastroparesis, is the member using prokinetic drugs (e.g., metoclopramide), or does the member have a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome?

Yes     No

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

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**ATTESTATION AND DOCUMENTATION**

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Submission of polysomnography conducted within the last 12 months

Submission of weight loss treatment plan within the past 6 months

**LENGTH OF AUTHORIZATION**

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**Renewal requests (see additional requirements below):**

1. Does the member continue to meet the criteria? **AND**

Yes     No

1. Is the member being treated with a maintenance dosage of the requested drug? **AND**

Yes     No

2. Is documentation attached verifying that the member has experienced improvement in OSA symptoms (e.g. Epworth sleepiness scale, sleep questionnaire) as a measurement of OSA symptoms?

Yes     No

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**Attachments**

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**Prescriber Signature (Required)**

**Date**

**I attest that all information is accurate.**                      Yes                      No

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.  
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826

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